



The Royal College of
Midwives

Evidence Based Guidelines *for* *Midwifery-Led Care in Labour*

Birth Environment



Practice Points

Ensure that pregnant women receive high quality care throughout their pregnancy, have a normal childbirth wherever possible, are involved in decisions about what is best for them and their babies, and have choices about how and where they give birth (DH 2004).

Respect for a woman's wishes and her involvement in decision making is essential to her care in pregnancy and labour (NICE 2007; DH 2004). The birth plan should be discussed in full with the midwife looking after the woman in labour.

Hospital is an alienating environment for most women, in which institutionalised routines and lack of privacy can contribute to feelings of loss of control and disempowerment (Lock and Gibb 2003; Steele 1995). The studies by Green et al. (1990) and Simkin (1992) found that control, or lack of it, was important to the women's experience of labour and their subsequent emotional well-being.

Trials have demonstrated the benefits to women of having a low-risk, midwife-led area as an alternative to the conventional labour ward (Birthplace in England Collaborative Group 2011; Hodnett et al. 2010; Hatem et al. 2008; Byrne et al. 2000; Hodnett 2000; Waldenstrom 1997; Hundley et al. 1994; McVicar et al. 1993).

The non-labour ward or radically modified environment is associated with lower rates of analgesia, augmentation and operative delivery, as well as greater satisfaction with care and positive effect on care givers (Birthplace in England Collaborative Group 2011; Hodnett et al. 2010; Hodnett et al. 2009).

Midwives should be aware of the influence the physical environment has on their practice (Hodnett et al. 2010).

Birth Environment

The environment in which a woman labours can have a great effect on the amount of fear and anxiety she experiences. Hospital is an alienating environment for most women, in which institutionalised routines and lack of privacy can contribute to feelings of loss of control (Lock and Gibb 2003; Steele 1995). Brown and Lumley (1994) found that the technology and intervention that has now become commonplace on many labour wards was implicated in women's dissatisfaction with labour. Increased anxiety brought on through loss of control can interfere with the normal effective physiology of labour (Steele 1995). The studies by Green et al. (1990) and Simkin (1992) found that control, or lack of it, was important to the women's experience of labour and their subsequent emotional wellbeing. It is not easy to separate the influence of the model of care from the physical environment on the outcomes. Hodnett et al. (2010) discuss the effect that the physical environment can have on practice, within the supportive social model of care. In 2009, Hodnett et al. undertook a pilot study aimed to investigate the impact of the physical environment on women and practitioners by making simple but radical modifications to a hospital labour room, which included the removal of the standard hospital bed and the addition of equipment to promote relaxation, mobility, and calm. The women were then randomly allocated either the modified or typical labour room. Though the pilot was small in numbers, the outcomes indicated that the physical environment modification had a positive effect on women and care providers. The philosophy of mobilisation in active labour was increasingly supported in the modified environment (Hodnett et al. 2009).

RCM (2008) Birth Centre Standards for England Standard 7.6 sets criteria of 'An environment that protects and promotes women's privacy and dignity, respecting their human rights and provides facilities to maintain adequate nutrition and hydration in labour.'

Respect for a woman's wishes, and her involvement in decision-making is essential to her care in pregnancy and labour (DH 2007, DH 2004). National Service framework maternity policy (DH 2004) pledged that service should "ensure that pregnant women receive high quality care throughout their pregnancy, have a normal childbirth wherever possible, are involved in decisions about what is best for them and their babies, and have choices about how and where they give birth" and the choice aspect remains within NHS future plans (DH 2010).

It would appear that women have better physical and emotional labour outcomes when they are involved in the decision making (Hodnett et al. 2010). Green et al.'s study (1990) found that good information was important to a woman's birth experience and also to her subsequent emotional well-being. The decision-making must extend to the woman's choice of companion(s), who should be made to feel welcome in the labour ward.

Birth planning is a continuous part of antenatal care. This requires a focussed discussion about place of birth, at which 'women should receive clear, unbiased advice and be able to choose where they would like their baby to be born' (DH 2007; DH 2004). The recent Birthplace in England study (Birthplace in England Collaborative Group 2011) looked at safety of births planned in 4 different settings: home, freestanding midwifery units, alongside midwifery units and obstetric units for women with straightforward pregnancies. It found that birth is safe wherever it takes place but there is a small but increased risk of adverse outcome for the neonate for nulliparous women associated with planned home birth. The outcomes for multiparous or in other midwife led birth environments were the same. The study did not look into reasons for this and further exploration into the variation is required. However, this information needs to be included in the discussions with women antenatally. The 'birth talk' and associated birth plan are essential opportunities for women and midwives to share information (NICE 2007). The birth plan should be discussed in full with the midwife looking after the woman in labour. Women often find it difficult to ask questions, so midwives need to encourage them to do so, and to act as advocate for the wishes expressed (Kirkham 1986).

Trials have demonstrated the benefits to women of less intervention and more mobility, in having a low-risk, midwife-led area as an alternative to the conventional labour ward (Birthplace in England Collaborative Group 2011; Hodnett et al. 2010; Hatem et al. 2008; Byrne 2000; Hodnett 2000; Waldenstrom 1997; Hundley et al. 1994; McVicar et al. 1993). The philosophy behind the provision of such units is to provide a 'homely' environment, where women can take more control and labour is managed with minimal intervention (Hodnett et al. 2010; Hundley et al. 1994). It has also been found that women who give birth in low-tech, midwife-led facilities, e.g. home or birth centres, require less pharmacological analgesia (Hodnett et al. 2010; Chamberlain et al. 1997; Skibsted and Lange 1992). Hodnett et al.'s (2010) review found that the alternative birth setting environment is associated with lower rates of analgesia, augmentation and operative delivery, as well as greater satisfaction with care. There was a non-statistically-significant trend towards higher perinatal mortality in the home-like setting, and the reviewers conclude that 'an over-emphasis on normality' may lead to delayed recognition of or action regarding complications. Walsh (2004) has challenged this conclusion from his own experience and suggests that midwives who work in this environment are 'astute assessors of normal birth' and highly skilled practitioners, who are active in performing repeated emergency drills. Hodnett et al. (2010) found, in their comparison of alternative and conventional labour and birth environments, that staff working in the 'alternative' settings all shared philosophies and guidelines that valued midwifery-led care. The study was not able to explore the separate influences of the physical environment and models of care such as, for example, continuity of caregiver, but concluded that the impacts of midwifery-led care and the nature of the birth setting are fundamentally interdependent in the chain of cause and effect leading to more positive outcomes.

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The guidelines have been developed under the auspices of the RCM Guideline Advisory Group with final approval by the Director of Learning Research and Practice Development, Professional Midwifery Lead.

The guideline review process will commence in 2016 unless evidence requires earlier review.

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Appendix A

Sources

The following electronic databases were searched: The Cochrane Database of Systematic Reviews, MEDLINE, Embase and MIDIRS. As this document is an update of research previously carried out, the publication time period was restricted to 2008 to March 2011. The search was undertaken by Mary Dharmachandran, Project Librarian (RCM Collection), The Royal College of Obstetricians and Gynaecologists.

Search Terms

Separate search strategies were developed for each section of the review. Initial search terms for each discrete area were identified by the authors. For each search, a combination of MeSH and keyword (free text) terms was used.

Journals hand-searched by the authors were as follows:

- Birth
- British Journal of Midwifery
- Midwifery
- Practising Midwife
- Evidence-based Midwifery